

Exhibit 20



North Shore-LIJ Health System is now **Northwell Health**

Occupational Medicine, Epidemiology and Prevention

May 3, 2016

Kevin Paul, Esq.
Simon, Greenstone, Panatier, Bartlett
3232 McKinney Avenue
Suite 610
Dallas, Texas 75204

Re: Doris Jackson

Dear Mr. Paul:

I am writing to report the results of my evaluation of the materials listed below pertaining to Ms. Doris Jackson. I have reviewed these materials in the context of my pre-existing knowledge, training, and experience in the field of occupational medicine. These materials are of the type I and other specialists in occupational medicine normally rely upon and are sufficient to form a reliable basis for my opinions contained within this report. All of the opinions stated in this report are given within a reasonable degree of medical certainty.

This report and the opinions stated in the report are based on the listed materials and my 24 years of training, education, and experience in the area of asbestos-related occupational medicine. Over the past 24 plus years, I have had the opportunity to evaluate and treat hundreds of patients with asbestos exposure, many of whom have asbestos related diseases.

patients in the metropolitan New York area. Over the past year alone, I have supervised the examination of or directly examined nearly 500 patients with asbestos exposure, as we have greatly expanded our clinical services. Over the course of the past 25 years, I have evaluated dozens of patients with malignant mesothelioma and lung cancer due to asbestos exposure. I have kept abreast of the scientific and medical literature regarding the diagnosis and causation of mesothelioma. I have personally evaluated cases of mesothelioma where the exposure was brief, and have also seen cases of mesothelioma in individuals whose only exposure to asbestos was from family members who worked with asbestos and brought their asbestos contaminated clothes home.

I have testified as an expert on the health effects of asbestos, providing both deposition and trial testimony. I have attached as Exhibit B a list of my deposition and trial testimony for the past four years.

My hourly rate of compensation for medical and document review and expert report generation is \$500/hour. My hourly rate for deposition and trial testimony is also \$500/hour.

Materials Reviewed:

I have had the opportunity to review the medical records and deposition transcripts of Ms. Jackson. I was provided with the following information:

1. Medical records of Doris Jackson
2. Deposition testimony of Doris Jackson 09/28/15 and 09/29/15 with exhibits
3. Exposure History Sheet
4. Death Certificate, Issued by The District of Columbia, Date of Death, October 28, 2015
5. Discovery answers served in the case
6. Expert Report, Mr. Sean Fitzgerald, May 1, 2016
7. Letter and final analytical results from S. Lewin to A. Weissler dated August 3, 1972
8. Memorandum from A. Weissler to R. Shaffner dated July 31, 1973
9. Cosmetic Toiletry and Fragrance Association documents
10. Company product testing documents produced in litigation
11. Proceedings of the Symposium on Talc, Washington DC by A. Langer, May 8, 1973

Ms. Jackson's Medical and Exposure History:

Ms. Jackson is an 84 year old woman who developed shortness of breath with exertion in September 2014, along with a cough and chest tightness. The shortness of breath worsened and Ms. Jackson went to Washington Hospital Center on November 3, 2014, where she was subsequently admitted. She had shortness of breath, a cough and

chest discomfort. A chest x-ray showed a very large left pleural effusion. Ms. Jackson had a thoracentesis on November 4, 2014, with approximately 1,500 cubic centimeters of fluid removed from the left chest. Her pulmonary symptoms improved following the fluid removal. The cytology showed carcinoma cells, with carcinoma cells also present in the cell block. No evidence of lymphoma or leukemia was noted on flow cytometry. Dr. Sharma, an oncologist, saw Ms. Jackson in the hospital after the thoracentesis cytology showed malignant cells. A CT angiogram was done on November 4, 2014 and showed only a large left pleural effusion with compressive atelectasis of the left middle and lower lobes. No pulmonary embolism was seen. There were ground glass opacities in the left upper lobe and right lung, suggestive of pulmonary edema, and less likely, alveolitis. An abdominal CT scan on November 6, 2014 showed a partially imaged large left pleural effusion with enhancing soft tissue along the medial pleura, suspicious for metastatic disease with a malignant pleural effusion. There was a right adrenal mass noted and a mixed solid/cystic left renal lower pole mass, and renal cell carcinoma should be considered. Gallstones were also noted. There was a large lipoma in the pelvis. A bone scan was negative for metastatic lesions but showed osteoarthritis. Dr. Christopher Eger, a thoracic surgeon, saw Ms. Jackson in the hospital. He recommended a thoracoscopy with fluid management with a pleurodesis and possibly a chest tube. Ms. Jackson wished to return the following week for surgery so that she could attend a funeral.

Ms. Jackson underwent a thoracoscopy on November 13, 2014 at Washington Hospital Center. At the time of surgery, Dr. Eber removed around 2,300 cubic centimeters of serosanguinous fluid and noted bulky posterior parietal pleural implants, which he biopsied. He then insufflated talc and inserted a chest tube. Additional talc was administered through the chest tube on November 15, 2014. The chest tube was removed on November 17, 2014, and she was discharged home later on November 17, 2014.

The pathology showed a malignant epithelial neoplasm, consistent with metastatic poorly differentiated carcinoma. The pathology was reviewed at UCLA Medical Center, and the pathology was felt to be malignant mesothelioma, biphasic type with 90% epithelioid subtype and focal sarcomatoid features. The staining patterns showed focal positivity for RCC and was positive for CA9.

Ms. Jackson had a mammogram on November 20, 2014 that showed no mammographic evidence of malignancy. Ms. Jackson went to see Dr. Frederick Smith, a medical oncologist, on November 20, 2014. He ordered a PET/CT scan. A PET/CT scan on November 24, 2014 showed a moderate, partially loculated left pleural effusion. There were multifocal regions of increasing FDG utilization within the pleural fluid, including some areas admixed with regions of higher density on CT which suggested pleurodesis-related findings, although malignancy could also account for the findings. NO definite extrathoracic disease was seen. There was a right adrenal low-density nodule that appeared to be an adenoma. A complex appearing left mid to lower pole renal lesion was seen, which appeared to be a cyst and a possible second nodule that could represent a renal cell carcinoma. Ms. Jackson started chemotherapy with Carboplatin and Alimta while she was in Maryland. She then moved to California and continued chemotherapy with Dr. Olevsky, and received her second cycle of chemotherapy at UCLA. [Records of

her chemotherapy were not available for my review; the records note that she received four cycles of neo-adjuvant chemotherapy with Alimta and Carboplatin.]

Dr. Robert Cameron, a thoracic surgeon, saw Ms. Jackson on February 4, 2015. In her intake form, she noted that she was exposed for over thirty years to ceiling pipes with degrading insulation while working as a teacher in the DC Public Schools. An MRI of the abdomen was done on February 5, 2015. There was a mass in the right adrenal gland. There was a non-enhancing lesion projecting from the lower pole of the kidney consistent with a simple cyst with a small focus of either hemorrhage or proteinaceous debris. A PET/CT scan on February 11, 2015 showed a small pericardial effusion. There was no lymph node enlargement. There was a stable right upper lobe ground glass nodule and right lower lobe scarring versus atelectasis. There was left greater than right biapical pleural parenchymal scarring. Dr. Karim Chamie, a urologist, saw Ms. Jackson on February 12, 2015 because of the pathology staining. Dr. Chamie reviewed the films and felt that Ms. Jackson had a benign left renal cyst and likely mesothelioma of non-renal origin. There was no lesion on the MRI that was suspicious for renal cell carcinoma, and he noted that while the tumor stained positive for "CAIX and RCC, there is a question of the specificity of these tests for non-renal tumors." Dr. Chamie did not recommend a change in treatment, and felt that an MRI in one year was a good idea to see if there were other suspicious lesions.

A PET/CT scan was done on April 14, 2015. There was a left-sided organized pleural effusion, increased FDG avidity and nodularity in the medial pleura and costophrenic sulcus with evidence of progressive disease. There was left paravertebral nodularity at the level of the aortic arch. There was increased SUV activity in the posterior hemithorax, and in the left lateral costophrenic sulcus. There was worsening of the left-sided mesothelioma. Ms. Jackson returned to Dr. Cameron on April 22, 2015. She had no new symptoms. Dr. Cameron wanted additional testing prior to making a further decision regarding potential treatment, including a stress echocardiogram and MRI of the chest/diaphragm for function of the left side. An echocardiogram was done on May 1, 2015 and showed a normal left ventricular size and normal function with an estimated left ventricular ejection fraction of 60-65%. There was grade 1 diastolic dysfunction, and borderline pulmonary hypertension.

A chest MRI on May 28, 2015 showed worsening of the left-sided mesothelioma. The left diaphragm was involved but there was no evidence of extension across the left hemidiaphragm or visualized intraperitoneal nodularity. There was limited excursion of the posterior left hemidiaphragm during maximum breathing. Ms. Jackson went to see Dr. Alina Katsman, a primary care physician, on June 4, 2015. Her hypertension and diabetes were under control. Dr. Katsman noted that surgery was planned for June 29th with Dr. Cameron. Dr. Katsman saw Ms. Jackson on June 15, 2015. She had a sore throat, increased cough and thick mucus. Dr. Katsman treated her for atypical pneumonia with antibiotics (azithromycin) and Albuterol as needed. Ms. Jackson returned to Dr. Katsman one week later; she was feeling better although she still had some mucus production.

Ms. Jackson was admitted to UCLA on June 28, 2015 for a left thoracotomy, left pleurectomy and decortication. Dr. Cameron performed the surgery on June 29, 2015. Dr. Cameron found that the left pleural tumor was particularly adherent to the area just posterior to the aortic arch, to the aortic arch, and the posterior chest wall. It was also adherent to the lung hilum, the pericardium as well as to the diaphragm. There were no endobronchial lesions noted but there was external compression of the bronchial tree on the left side. Dr. Cameron then performed betadine washes of the chest cavity for a total of 45 minutes. During surgery, Ms. Jackson lost approximately 4 liters of blood and received 12 units of packed red blood cells, three units of fresh frozen plasma, one cryoprecipitate pack and one platelet pack. The pathology showed malignant biphasic mesothelioma. There were 4 of 8 lymph nodes positive for metastases, and the pericardial fat and pericardial lymph node was positive for mesothelioma. There was evidence of invasion into the chest wall. Ms. Jackson's tumor was staged T3N2M0.

She received blood transfusions after surgery as well as blood pressure support with phenylephrine and albumin. A small to moderate left sided pneumothorax developed after surgery but improved. She then developed hypotension on June 30th, with a systolic blood pressure in the 70s and elevated heart rate. An echocardiogram showed normal wall motion, no effusions or sign of tamponade, a normal right ventricle and a small collapsible inferior vena cava. She had an elevated troponin level and diffuse ST elevation and PR depressions noted on her electrocardiogram, which were consistent with pericarditis. Dr. Suh, the cardiologist, recommended colchicine for one month for the pericarditis and to prevent post-operative atrial fibrillation. They also recommended a beta blocker if she remained tachycardic, rather than the diltiazem since she was hypotensive. Ms. Jackson continued to have episodes of hypotension in the days after surgery and needed to have fluid boluses, as well as pain. She developed a pleural effusion on the right side and underwent an ultrasound-guided thoracentesis of the right chest on July 5, 2015. She had pain on the right side, which Ms. Jackson attributed to the chest tube. A CT angiogram was ordered to ensure that she didn't have a pulmonary embolism; no pulmonary embolism was seen. Small bilateral pneumothoraces and bilateral pleural effusions were noted, and a moderate pericardial effusion.

She had three chest tubes removed on July 7th, and one remained until July 10th. Ms. Jackson was also having difficulty eating, and had severe constipation, abdominal bloating, frequent burping and pain in her right mid-upper abdomen after drinking fluid. Gastroenterology consulted and felt it might be related to constipation or a mild ileus. If her epigastric pain did not resolve, then an upper endoscopy would be scheduled. The epigastric pain worsened, and Ms. Jackson had an esophagoscopy on July 12, 2015. Upon placement of the endoscopy, there was a white-yellow exudate circumferentially covering the upper esophagus and small areas that appeared bluish-purple in color. There was large amount of food present in her esophagus, with the surrounding esophagus appearing erythematous. Dr. Lewis, the gastroenterologist, was unable to safely remove the food bolus and was concerned around the inflammation and that there might be a stricture.. She was then emergently intubated to prevent aspiration, as well as intra-procedure hypotension and concomitant esophageal obstruction, and Ms. Jackson was transferred to

the intensive care unit and treated for respiratory failure and hypotension. A chest x-ray and neck films were ordered to ensure that there was no pneumomediastinum.

Ms. Jackson was then transferred to the operating room, where Dr. Cameron performed a bronchoscopy and flexible esophagoscopy, and removed the food in the distal esophagus and proximal stomach. Multiple undigested medication pills were also removed. There was no evidence of ischemia in the esophageal wall or obstruction at the gastroesophageal junction. Ms. Jackson developed atrial fibrillation post-operatively, and was treated with Amiodarone.

Ms. Jackson was extubated on July 14th, and continued to have the nasogastric tube that had been placed at the time of the second surgery. She had a swallowing study to see if she was at risk for further aspiration. She had an abnormal swallowing study and there was laryngeal penetration after the swallow. She had an edematous larynx as well. An esophagram barium swallow on July 15th showed delayed esophageal emptying with tapered narrowing of the distal esophagus and thickened mucosal folds of the distal esophagus. She was placed on thick pureed foods, and the nasogastric tube was discontinued on July 16th. She remained in and out of atrial fibrillation. An esophagram showed contrast traveling through the esophagus to the stomach and into the duodenum. Ms. Jackson was able to cough well enough to clear thin liquids. She remained in atrial fibrillation, and was on subcutaneous Lovenox along with Digoxin. A CT of the brain and CT brain angiogram and CT neck angiogram were performed on July 19th. There was no evidence for an acute infarct, intracranial hemorrhage or mass effect. There was no significant stenosis or occlusion involving the intracranial or cervical vasculature. There was a moderate right pleural effusion. There was partially visualized atelectasis versus consolidation in the left upper lobe. She was discharged home on July 21, 2015, and was to have home health services.

Dr. Katsman saw Ms. Jackson on July 31, 2015. She was swallowing thick liquids only and remained very constipated. A chest x-ray on July 31, 2015 showed a small left apical pneumothorax that was decreased. There were small bilateral pleural effusions, left greater than right. An abdominal x-ray showed a non-obstructive abdominal bowel gas pattern with a moderate stool burden in the descending/rectosigmoid colon. She tested negative for Anti-Hu antibodies (an antibody often present in those with paraneoplastic syndrome). Ms. Jackson was evaluated by Dr. Maggie Ham on August 7, 2015. Ms. Jackson was having difficulty getting enough calories on a thick liquid diet and had constant nausea. She had severe constipation. Dr. Ham noted that the persistent dysphagia could be related to an inflammatory process in the distal esophagus or malignancy. She recommended a repeat endoscopy, which Ms. Jackson and her family were reluctant to undertake given the complications surrounding the last endoscopy. She ordered a proton pump inhibitor as well as a barium swallow and nutrition consult. Dr. James Lee from cardiology saw Ms. Jackson on August 17, 2015. She was having shortness of breath and dyspnea and was on one liter of oxygen. Dr. Lee planned a repeat echocardiogram because of the possibility of a pericardial effusion noted on prior echocardiograms, and also felt that she needed anti-coagulation for the atrial fibrillation. He switched her to Apixaban. A CT scan of the abdomen and pelvis was done on August

13, 2015. There were indeterminate enhancing lesions of the liver and left kidney. A small enhancing nodule was seen adjacent to the left kidney that was hyperenhancing when compared to the spleen, and could represent a small splenule, but a peritoneal nodule could not be excluded. Bilateral pleural effusions with scattered reticular markings of the left lower lobe were noted. Gallstones were present.

Dr. Percy Lee, a radiation oncologist, saw Ms. Jackson on August 20, 2015. Ms. Jackson reported feeling weak and has been essentially bed bound after her long hospital stay. She was short of breath with very minimal exertion, and had lost over thirty pounds in the prior few months. She was still on a pureed diet due to dysphagia, and had more sputum production. Dr. Lee did not feel that Ms. Jackson was a good candidate for adjuvant chemotherapy to the chest wall due to her poor functional status. An echocardiogram was done on August 24, 2015. There was normal left ventricular size with borderline left ventricular septal hypertrophy. The left ventricular ejection fraction was about 55-60% and grade I diastolic dysfunction was present. There was a trace pericardial effusion. There was mild pulmonary hypertension.

Ms. Jackson went into hospice care [records not available for my review]. She died on October 28, 2015. She was 83 years old.

Past Medical History: Ms. Jackson had a history of a right breast lumpectomy in 2001 for ductal carcinoma in situ, followed by radiation to the right breast (4600 cGy to the right breast with a 1600 cGy boost to the right breast biopsy cavity). She had a left knee replacement in 2013 and a hysterectomy in 1975. She has a history of hypertension and diabetes. She had a stroke in 2011 that affected her right eye.

Cigarette Smoking History: Ms. Jackson never smoked cigarettes.

Occupational and Environmental History: Ms. Jackson worked as an elementary school teacher from 1954-1990. She worked at the Edmonds Elementary School, the HD Cooke Elementary School, the Powell Elementary School and Weatherless Elementary School. In her deposition testimony she did not recall any ceiling pipes with degrading insulation.

Ms. Jackson used Cashmere Bouquet talcum powder “before [she] was 12 and 13 years old”, and also noted using powder while she was younger. Thus, she used Cashmere Bouquet starting in the 1940s and continuing for decades. She applied Cashmere Bouquet under her arms after bathing, and also put it in her shoes. She also stated that she used the powder on a daily basis even when she didn’t “go into the tub.” She shook the powder out of the can, and applied it to her body. Ms. Jackson used Cashmere Bouquet on a daily basis until she retired, when she noted that it was no longer available. She also noted that her mother used Cashmere Bouquet powder. They lived in a small apartment and shared one bathroom.

Conclusion: Ms. Jackson suffered and died from malignant mesothelioma of the left chest as a result of her exposure to asbestos from cosmetic talc. She underwent surgery

and had significant complications requiring emergent follow-up surgery. Eventually, she succumbed from the mesothelioma.

Based on the information available, it is my opinion, to a reasonable degree of medical certainty that Ms. Jackson's exposure to asbestos-containing talcum powder led to the development of her mesothelioma. She began using Cashmere Bouquet in the 1940s and continued to use it daily for decades.

The methodology and basis for my opinions follows standard methods of the medical and scientific community. Asbestos is the most well known cause of mesothelioma, and the causation of mesothelioma has been established by the quantitative history of exposure to asbestos. Thousands of individuals, from myriad professions and exposure situations have developed mesothelioma as a result of either direct or indirect exposure to asbestos. The reliance on the history of exposure to asbestos was used by seminal studies by Newhouse, Wagner and Selikoff in the 1960s, who attributed mesothelioma to asbestos exposure based solely on the history of exposure. The increased risks for mesothelioma exist for individuals who both worked directly with asbestos products and for those who worked adjacent to or in the vicinity of others who were using asbestos products, which is known as "bystander" exposure.

Asbestos and Malignant Mesothelioma General Opinions: Occupational Medicine is the field of medicine that deals with exposures to substances, toxins, conditions and agents in the workplace that are associated with increased risks of diseases. It exists as a subspecialty of Preventive Medicine that deals with identifying ways to prevent people from becoming ill. This includes identifying the sources, agents or catalysts that increase the likelihood of someone developing a disease, illness, or detrimental condition, and educating people on how to eliminate, avoid, and/or mitigate those risks. To put it simply, Occupational Medicine and Preventive Medicine involves searching for and identifying causes of diseases. This knowledge is important for those who are already ill: elimination of the catalysts can eliminate or mitigate the illness. It is also important from a public health point of view: to a large extent, the higher purpose of Occupational Medicine and Preventive Medicine is to educate and warn the public on how to eliminate, avoid, or mitigate the risks of diseases at the workplace, and to provide guidance to governments and businesses on appropriate regulations and standards concerning workplace health and safety.

One of the essential tasks of a physician of Occupational Medicine, when dealing with an individual patient, is the taking of a proper occupational history. Standard medical histories usually involve the patient explaining their reason for seeking medical attention; a listing of current symptoms, conditions, allergies, medications and other relevant medical problems; and providing some family and social history. Occasionally, a standard medical history may-but doesn't always-include identifying the patient's occupation.

A full occupational history, on the other hand, will go into details of a patient's entire work history, including details concerning their tasks and duties and their working